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M E M O R A N D U M

To: **American Society of Transplant Surgeons**

From: **Peter T. Thomas and Theresa T. Morgan**

Date: December 17, 2010

Re: **Update on Establishment of Essential Health Benefits as Mandated by ACA**

Starting in 2014, the Patient Protection and Affordable Care Act ("Affordable Care Act" or "ACA") requires all qualified health plans, including Exchange plans and small group and individual plans offered outside of state Exchanges, to cover "essential health benefits." Not only will this benefit package become the standard package of benefits offered under private insurance, it will also be linked to the operation of the lifetime and annual caps provisions (i.e., lifetime and annual caps may apply to non-essential benefits).

The Department of Health and Human Services (HHS) is responsible for issuing regulations determining the scope of the essential health benefits categories as outlined by the Affordable Care Act. Data and reports from the Institute of Medicine (IOM) and Department of Labor (DOL) will inform their regulations. The ACA statute also lays out criteria and limitations the Secretary must follow as the regulations on the essential benefits package are developed. For example, the bill mandates that as the agency is defining the package, the Secretary may not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life. A full set of statutory requirements are reprinted from the ACA at the end of this memorandum.

HHS has indicated that it is expecting to release the proposed regulations in the fall of 2011.

Institute of Medicine Activities on Essential Health Benefits

HHS has requested the IOM conduct a consensus study regarding criteria for determining whether plans within the exchanges offer the essential health benefits package. The IOM has already assembled a committee to conduct the study. As part of their study, the committee asked

stakeholders to comment on 10 questions related to developing criteria for the essential health benefits package.

The committee will hold at least two public meetings and two closed meetings. Although the agenda for the first public meeting, scheduled for January 13 and 14, has not been released, we have been in contact with the IOM staff and have assisted in planning the first meeting. For instance, on January 13th, the IOM committee will discuss four categories of benefits with individual panels made up of provider and consumer groups. On the 14th, the IOM committee will likely discuss the remaining categories of benefits listed in the statute, as well as permit public comment.

It is also clear from our discussions with the study leaders that the IOM will be honing in on the cost of the overall package and will be driven by data. Although they are expected to establish criteria only, and will not be specifying covered benefits within each category, they will be weighing the potential costs associated with the criteria they establish.

Department of Labor Activities on Essential Health Benefits

On Wednesday, December 15, the Department of Labor conducted a briefing regarding its responsibilities in defining the essential benefits package as mandated by the Affordable Care Act. The bill instructs DOL to inform the HHS Secretary's determination as to the scope of the essential benefits package by surveying employer-sponsored coverage to determine the benefits covered by the "typical employer plan." The DOL report will inform HHS's rulemaking on the essential benefits package.

The Bureau of Labor Statistics (BLS) staff at Wednesday's meeting indicated the shortcomings of their process and data and we unable to offer satisfying solutions to those limitations. Specifically, BLS claims they lack the statutory authority to mandate employers to provide information on their health benefits plans. The data collection is all voluntary and comes to the Department in a wide variety of forms and formats. In addition, the Affordable Care Act did not authorize any funding for BLS to conduct a new or separate survey from the annual survey BLS normally conducts. A major problem arises when the data BLS collects is not specific enough to meaningfully inform HHS as to certain benefits specifically listed in the statute, such as "rehabilitative and habilitative services and devices, chronic disease management, and behavioral health treatment," all terms used in the ACA.

Currently, BLS collects data from employers on an array of benefits provided to employees, through the National Compensation Survey. The National Compensation Survey benefits series is an annual publication that collects detailed provisions and incidence data on many employer provided benefits, including health benefits. The most recently collected data derives from the 2009 National Compensation Survey: Health and Retirement Plan Provisions in Private Industry in the United States. Employers submitted data sources ranging from thick booklets on benefits to brief plan pamphlets, which provide little in-depth data on services covered. This survey only covers the private industry, and as a result, federal, state and local government workers, the military, agricultural workers, and other important groups are not included.

BLS is unable to require employers turn over specific plan information relevant to the established categories within ACA. BLS must use search terms to locate relevant information within a variety of sources, a process that makes it very difficult to find data on coverage of specific benefits. For instance, a recent BLS search for the term “rehabilitative and habilitative services and devices” resulted in very few – if any – “hits.” Indeed, a search through the previous national surveys finds the only reference to “rehabilitation” is within the description of skilled nursing facility services and references to substance abuse treatments. This same dynamic is at plan with terms such as kidney dialysis and organ and tissue transplantation, to name a few.

BLS has not traditionally catalogued an extensive number of services for the National Survey. For instance, the 2008 survey catalogued only the following services:

1. Hospital room and board
2. Inpatient surgery
3. Outpatient surgery
4. Physician office visit
5. Skilled nursing facility
6. Home health care
7. Hospice care

To counteract this shortcoming, DOL has created a short list of service names that it will search, in addition to other services it already uses. Accordingly, the National Compensation Survey is currently capturing information on the incidence and coverage limits of twelve additional health services. These include:

1. Emergency room visits
2. Ambulance services
3. Maternity care
4. Diabetes care management
5. Kidney dialysis
6. Physical therapy
7. Durable medical equipment
8. Prosthetics
9. Infertility treatment
10. Sterilization
11. Gynecological exams
12. Organ/tissue transplantation

In early 2011, NCS will produce estimates of the percent of private industry workers with access to health plans that cover each of the twelve aforementioned health services. It will also provide information on the limits imposed on these services. This is very concerning considering the limitations of the survey system and authority in effect at the Department of Labor. The likely result is that such benefits will be undercounted as they will not be easy to identify, given the limitations of the DOL data collection system. Worse yet, the DOL staff we spoke with did not

seem to have any significant plan to counteract or augment this process so that more reliable data is available.

Approximate Timeline of Related Events

Ongoing:	DOL reviews data on typical employer plan
December 6, 2010:	First IOM Deadline for Stakeholder Comments
January 13-14, 2011:	IOM holds first public meeting
March 2011:	DOL releases report on typical employer plan
June 2011:	IOM releases results of consensus study on criteria for essential benefits package
November 2011:	HHS issues proposed regulation with comment period

Relevant Web Sites and Data Sources

HHS Implementation Center: http://www.healthcare.gov/center/

IOM Determination of Essential Health Benefits site:
http://www.iom.edu/Activities/HealthServices/EssentialHealthBenefits.aspx

BLS data sites:

National Compensation Survey Publications List http://www.bls.gov/ncs/ncspubs_2009.htm

National Compensation Survey: Health and Retirement Plan Provisions in Private Industry in the United States, 2009, http://www.bls.gov/ncs/ebs/#bulletin_details

Table 14. Medical care benefits: Coverage for selected services, private industry workers, National Compensation Survey, 2008
http://www.bls.gov/ncs/ebs/detailedprovisions/2008/ownership/private/table14a.pdf

National Compensation Survey: Health and Retirement Plan Provisions in Private Industry in the United States, 2005, http://www.bls.gov/ncs/ebs/sp/ebbl0022.pdf

The National Compensation Survey: Glossary of Employee Benefit Terms
http://www.bls.gov/ncs/ebs/detailedprovisions/2008/glossary_2008_2009.pdf

Employee Benefits Survey FAQs: http://www.bls.gov/ebs/ebsfaq.htm#TYP

ACA Statutory Provision on Essential Health Benefits (What is required by the ACA?)

(b) Essential Health Benefits-

(1) IN GENERAL- Subject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:

(A) Ambulatory patient services.
(B) Emergency services.
(C) Hospitalization.
(D) Maternity and newborn care.
(E) Mental health and substance use disorder services, including behavioral health treatment.
(F) Prescription drugs.
(G) Rehabilitative and habilitative services and devices.
(H) Laboratory services.
(I) Preventive and wellness services and chronic disease management.
(J) Pediatric services, including oral and vision care.

(2) LIMITATION-

(A) IN GENERAL- The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To inform this determination, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, including multiemployer plans, and provide a report on such survey to the Secretary.

(B) CERTIFICATION- In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

(3) NOTICE AND HEARING- In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.

(4) REQUIRED ELEMENTS FOR CONSIDERATION- In defining the essential health benefits under paragraph (1), the Secretary shall--

(A) ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that--

> (i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and
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> (ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network;

(F) provide that if a plan described in section 1311(b)(2)(B)(ii) (relating to stand-alone dental benefits plans) is offered through an Exchange, another health plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under paragraph (1)(J); and

(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains--

> (i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;
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> (ii) an assessment of whether the essential health benefits needs to be modified or updated to account for changes in medical evidence or scientific advancement;
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> (iii) information on how the essential health benefits will be modified to address any such gaps in access or changes in the evidence base;
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> (iv) an assessment of the potential of additional or expanded benefits to increase costs and the interactions between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and

(H) periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).

(5) RULE OF CONSTRUCTION- Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.